STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146047	A. BUILDING _____ B. WING _____	12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Annual Licensure and Certification An Extended Survey was conducted	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review, the facility failed to obtain informed consent for the use of a restraint, care plan the use of a restraint with a reduction plan in place, and document a medical symptom justifying the use of a restraint for one of three residents reviewed for restraints in the sample of fifteen. Findings include: On 12/01/14 at 1:00 p.m., E17, Assistant Administrator, stated the facility currently has no residents using restraints. On 12/01/14 at 1:40 p.m., R1 was ambulating in an enclosed walker near the television area of the facility's rehabilitation wing. E7, Certified Nursing Assistant, asked R1 to open the enclosed walker, and R1 was unable to follow this command. E7 then stated that R1, "(R1) cannot always open it when you ask (R1)". R1's current medical record does not contain an	F 221		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 221	Continued From page 1 assessment with alternatives attempted or documentation of informed consent obtained prior to initiation of the use of R1's enclosed walker. R1's care plan dated 9/2/14 did not document R1's enclosed walker as an identified problem with goals and interventions for a reduction plan in place. R1's current electronic physician order for the use of R1's enclosed walker does not document a medical symptom justifying the use of R1's enclosed walker or any parameters for its use. The facility's Restrictive Devices policy dated 1/20/11 states, "All restrictive devices must have the consent of the resident or if incompetent the responsible party...(E18, Restorative Nurse) will complete assessment form and together with the interdisciplinary team they will assess the need for the device...The use of any restrictive device must be reflected in the resident care plan...the continued use of restrictive devices will be assessed for reduction and elimination by the care plan team." On 12/02/14 at 12:00 p.m., E8, Minimum Data Set/Care Plan Coordinator, stated, "(R1's enclosed walker) didn't fit what I consider a restraint because it doesn't limit access to (R1's) own body. (R1) cannot open or release it (enclosed walker) when asked." E8 then stated no assessment with alternatives attempted or informed consent was obtained prior to initiation of R1's enclosed walker. E8 also stated that R1 currently does not have a care plan in place addressing the use of R1's enclosed walker.	F 221		
F 225	483.13(c)(1)(ii)-(iii), (c)(2) - (4)	F 225		

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F 225 SS=F	Continued From page 2 INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225		

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This REQUIREMENT is not met as evidenced by:
Facility noncompliance resulted in two deficient practices.

1. Based on record review and interview, the facility failed to identify potential physical abuse, ensure that actual physical abuse was reported immediately to the Administrator, investigate to prevent further potential abuse and report to the State agency for four of 15 residents (R1, R2, R9, R11) reviewed for abuse, in a sample of 15. This failure has the potential to affect all 70 residents.

Findings include:

The Facility's Abuse and Neglect Prevention Policy, dated 10/18/13, documents "the Administrator is the abuse coordinator." The same policy documents: "All alleged violations involving mistreatment, neglect or abuse including injuries of unknown source...are to be reported immediately to the administrator...and to other officials in accordance to state law including to the state survey and certification agency." The facility "will investigate all allegations of abuse...all incidents shall be initially reported in writing to (state agency) as soon as possible, but ought not to exceed 24 hours after discovery of the incident." The same policy documents under "Resident as Perpetrator of Abuse Protocol: a staff member or individual who observes abuse or neglect perpetrated by another resident shall immediately report the matter to the abuse coordinator."

On 12/1/14 E17 Assistant Administrator stated the facility had no allegations of abuse for the

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year.

R2's incident report dated 6/7/14 at 3:18 p.m. documents R2 "extremely aggressive towards staff and other residents. Punched (E4) NA (Nursing Assistant) in the nose with (R2) fist. Also tried to bite (E4). Hit at (R15) CNA (Certified Nursing Assistant). Made attempts to bite other staff. Pushed at and tried to bite (R1). Bared (R2's) teeth at (R1)." The same form documents under the section titled agencies/people notified: no notifications found. The same form documents under the section titled signatures, E2 DON (Director of Nursing) was notified of the incident on 6/11/14 and E1(Administrator) was notified 7/17/14. This incident form did not document the state agency was informed.

R2's incident report dated 6/18/14 at 11:55 p.m. documents R2 was standing outside R9's room, when R9 came out. R9 grabbed R2 by the arm and shoved R2. R2 then punched R9 in the left jaw area. The same form documents under the section titled agency/people notified; family/(POA) Power of Attorney. The same form documents under signatures: E2 (DON) notified on 6/20/14 with no documentation of notification to E1 (Administrator). This incident form did not document the state agency was informed.

R11's incident report dated 11/16/14 at 10:19 p.m. documents R11 was trying to get R2 away from R13 by pulling on R2's shirt sleeve. R2 began punching R11 in the head, R11 pushed R2's hands away. R2 stumbled backwards, lost balance and fell on the floor, landing on R2's hip. This computerized form documents under agencies/people notified: family. The same form documents under signatures: E1 notified 11/18/14

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and E2 (DON) notified 11/17/14. R2's computerized incident report for the same incident with R11 dated 11/16/14 contains a hand written notation documenting E2 (DON) was notified on 11/16/14.

On 12/2/14 at 1:30 p.m. E1 (Administrator) verified E1 did not investigate the incidents on 6/7/14, 6/18/14 and 11/16/14 as abuse. E1 also verified the signature page on the incident forms "could be the first time the incident was reviewed."

2. Based on interview and record review the facility failed to do a fingerprint based background check for two direct care staff members (E3 Certified Nursing Assistant), E4 (Licensed Practical Nurse/LPN). This failure has the potential to affect all 70 residents.

Findings include:

Facility's Health Care Worker Background Check Policy, dated 11/10/13, states, "It is the facility's policy that all employees have a criminal history check completed...The employee shall go to the livescan vendor and have his or her fingerprints collected electronically and transmitted to the Department of State Police within 10 working days after signing the authorization and disclosure form."

1. Facility's Employee List, dated 12/1/14 states that E3 (Certified Nursing Assistant) was hired on 8/8/14.

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F 225	Continued From page 6 E3's Health Care Worker Background Check Authorization documents that E3 signed this disclosure on 8/8/14. E3's Employee file has no documentation stating the date E3's fingerprinting was done. 2. Facility's New Employee document, dated 8/1-12/1/14, documents that E4 (LPN) was hired on 11/18/14. E4's Health Care Worker Background Check Authorization documents that E4 signed this disclosure on 11/18/14. E4's Agency fingerprinting submission form states that E4 has an appointment on 12/4/14 for E4's fingerprinting to be done. On 12/2/14 at 11:20 a.m., E5 (Payroll Manager) stated, "We attempt to fingerprint new employees within 30 days. E3 was fingerprinted on 9/17/14 there is no confirmation slip but it was done on the same day as E3's drug testing...E4's hire date was 11/18/14 and E4's fingerprint appointment is 12/4/14. E4 has been working on the floor since E4 was hired. " E1 (Administrator) was present and confirmed this information. The Resident Census and Condition Report, dated 12/1/14 and signed by E8 MDS Coordinator (Minimum Data Set Coordinator), documents 70 residents reside in the facility.	F 225		
F 226 SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit	F 226		

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mistreatment, neglect, and abuse of residents and misappropriation of resident property.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to follow operational policies and procedures regarding the identification, reporting, investigation and prevention of physical abuse for four of 17 residents (R1,R2, R9, R11) reviewed for abuse, in a sample of 17. This failure has the potential to affect all 70 residents.

Findings include:

The Facility's Abuse and Neglect Prevention Policy dated 10/18/13 documents "the Administrator is the abuse coordinator." The same policy documents: " all alleged violations involving mistreatment, neglect or abuse including injuries of unknown source...are to be reported immediately to the administrator...and to other officials in accordance to state law including to the state survey and certification agency." The facility "will investigate all allegations of abuse...all incidents shall be initially reported in writing to (state agency) as soon as possible, but ought not to exceed 24 hours after discovery of the incident." The same policy documents under "Resident as Perpetrator of Abuse Protocol: a staff member or individual who observes abuse or neglect perpetrated by another resident shall immediately report the matter to the abuse coordinator."

On 12/1/14 E17 (Assistant Administrator/AA) stated the facility had no allegations of abuse for

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F 226	Continued From page 8	F 226		

the year.

R2's incident report dated 6/7/14 at 3:18 p.m. documents R2 "extremely aggressive towards staff and other residents. Punched (E4) NA (Nursing Assistant) in the nose with (R1) fist. Also tried to bite (E4). Hit at (R15) CNA (Certified Nursing Assistant. made attempts to bite other staff. Pushed at and tried to bite (R1). Bared (R1's) teeth at (R1)." The same form documents under the section titled agencies/people notified: no notifications found. The same form documents under the section titled signatures, E2 (DON/Director of Nursing) was notified of the incident on 6/11/14 and E1(Administrator) was notified 7/17/14. This incident form did not document the state agency was informed.

R2's incident report dated 6/18/14 at 11:55 p.m. documents R2 was standing outside R9's room, when R9 came out R9 grabbed R2 by the arm and shoved R2. R2 then punched R9 in the left jaw area. The same form documents under the section titled agency/people notified; family (POA/Power of Attorney. The same form documents under signatures: E2 (DON) notified on 6/20/14 with no documentation of notification to E1 Administrator. This incident form did not document the state agency was informed.

R11's incident report dated 11/16/14 at 10:19 p.m. documents R11 was trying to get R2 away from R13 by pulling on R2's shirt sleeve. R2 began punching R11 in the head, R11 pushed R2's hands away. R2 stumbled backwards, lost balance and fell on the floor, landing on R2's hip. This computerized form documents under agencies/people notified: family. The same form documents under signatures: E1 (Administrator)

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F 226	Continued From page 9 notified 11/18/14 and E2 (DON) notified 11/17/14. On 12/2/14 at 1:30 p.m. E1 (Administrator) verified E1 did not investigate the incidents on 6/7/14, 6/18/14 and 11/16/14 as abuse. E1 also verified the signature page on the incident forms "could be the first time the incident was reviewed." On 12/2/14 at 1:10 p.m. E2 DON (Director of Nursing) stated after a resident to resident altercation the nurse would notify E2 and E2 would decide if E1 (Administrator) "needed to be notified." E2 stated resident to resident altercations become abuse when there is "more than one target but E1 Administrator "makes the final decision." On 12/2/14 at 1:20 p.m. E6 CNA (Certified Nursing Assistant) stated the abuse coordinator is E9 (Social Service Director). E6 stated if a resident hit another resident it would be resident to resident abuse...report to nurse..the nurse would report to E2 DON (Director of Nursing)...then E9. On 12/2/14 at 1:15 p.m. E7 CNA (Certified Nursing Assistant) stated resident to resident altercations are a "behavior...happens all the time back here." The Resident Census and Condition Report, dated 12/1/14 and signed by E8 MDS Coordinator (Minimum Data Set Coordinator), documents 70 residents reside in the facility.	F 226		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Facility noncompliance resulted in three deficient practices.

1. Based on interview, observation and record review the facility failed to implement new fall interventions after each fall and failed to follow a fall prevention care plan for one of seven residents (R1) reviewed for falls in the sample of fifteen. This failure resulted in R1 falling and sustaining a hairline fracture of R1's nose, and requiring sutures to R1's forehead.

Findings include:

R1's Incident Report dated 1/17/14 documents R1 fell at the facility while using an enclosed walker on 1/17/14. This same report documents no new intervention was implemented and instructed facility staff, "Continue to monitor."

R1's Incident Report dated 1/26/14 documents R1 fell at the facility while using an enclosed walker on 1/26/14. This same report documents the intervention, "Staff reminded to keep (R1) in direct supervision at all times," was implemented.

R1's Incident Report dated 3/13/14 documents R1 fell while using an enclosed walker at the

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facility on 3/13/14. This same report documents no new intervention was implemented and the intervention, "Remind staff (R1) needs constant supervision while in (enclosed walker)," was continued.

R1's Care Plan dated 4/14/14 documents the following interventions: "Continue to monitor...remind staff that (R1) needs supervision at all times while in the (enclosed walker)...remind staff to keep (R1) in direct supervision at all times when (R1) is in (enclosed walker).

R1's Incident Report dated 5/6/14 documents R1 fell at the facility on 5/6/14. This same report documents, "Heard cluttering sound down hallway. (R1) had tipped over (enclosed walker). Lying on side. Has a half inch size gash on right side of forehead. Has a quarter inch horseshoe shaped gash on nose. Forehead and nose both bleeding...took resident to (local emergency department) to be evaluated."

R1's Emergency Room record dated 5/6/14 documents R1 had a three centimeter laceration to R1's forehead, and R1 received four sutures to repair the laceration. This same record documents R1 received a Computerized Tomography scan of the head, diagnosing a bilateral nasal fracture.

On 12/04/14 at 10:05 a.m., E2, Director of Nursing, verified that R1's fall with injury on 5/6/14 was unwitnessed.

On 12/4/14 at 11:00 a.m., E1, Administrator, stated that E1 expects a new intervention to be implemented after a resident falls to prevent further falls. E1 also verified no new interventions

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were implemented after R1's falls on 1/17/14 and 3/13/14. E1 then stated that E1 expects facility staff to follow R1's care plan, and verified the interventions on R1's fall prevention care plan dated 4/14/14 were not followed on 5/06/14.

2. Based on interview and record review the facility failed to investigate, analyze and educate staff for two incidents involving resident injury for R18 and R19 in the supplemental sample.

Findings include:

R19's incident report dated 12/15/13 documents unidentified CNA (Certified Nursing Assistant) asked "the nurse to check (R19) because another CNA, E12 "just made incident to (R19) while being positioned." When the unidentified nurse went to check R19, E12 explained that R19 hit R19's head with R19's right siderail when E12 was performing morning cares." The same form documents under section titled Description of action taken: "...checked the head area. noted right forehead is red and hematoma, also observed facial grimaces of pain while doing assessment." The same form documents under signatures: E1 Administrator notified 3/17/14 and E2 DON (Director of Nursing) notified 12/17/13.

E12's CNA personnel file reviewed and did not contain education following the incident on 12/15/13.

R18's incident form dated 1/22/14 documents R18 complained of discomfort and tells nurse R18's face "is hit by the lifting machine while...helped R18 transfer from the wheelchair to the recliner." The same form documents under Description of Action Taken: "noted redness on

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R18's left face. Applied ice pack on R18's left face." The same form documents the incident was witnessed by E9 (SSD/Social Service Director).

On 12/3/14 at 2:15 p.m. E9 (SSD) stated during the incident on 1/22/14 the lifting machine did not hit R18. E9 verified E9 did not fill out a witness statement.

On 12/3/14 E1 Administrator provided E11's CNA (Certified Nursing Assistant) personnel file which did not contain education following the incident on 1/22/14. E1 identified E11 as the CNA involved in the incident dated 1/22/14.

On 12/3/14 at 2:15 p.m. E1 stated "I did not see concern for the incidents on 12/15/13 and 1/22/14. E1 stated "I know the staff and in life, things happen." E1 verified additional inservices were not held after the incidents on 12/15/13 and 1/22/14.

3. Based on interview and record review, the facility failed to ensure that one of three residents (R4) reviewed for oxygen administration in the sample of fifteen was kept safe while oxygen was in use.

Findings include:

On 12/02/14 at 10:35 a.m., R4 was sitting under an electric hair dryer in the facility's beauty shop. R4 was wearing a nasal cannula and was receiving oxygen from a portable oxygen tank attached to the back of R4's wheelchair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146047	A. BUILDING _____ B. WING _____	12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY VILLAGE	1200 EAST GRANT STREET MACOMB, IL 61455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 14 On 12/02/14 at 10:37 a.m., E13, Hairdresser verified that R4's oxygen was in use while R4 sat under a hot electric hair dryer. On 12/02/14 at 10:46 a.m., E1, Administrator, confirmed the presence of oxygen administration in the beauty shop during use of an electric dryer and stated, "It (oxygen use) shouldn't be in there. (E13) didn't know that it shouldn't be." On 12/04/14 at 8:30 a.m., E1, Administrator stated the facility does not have a policy in place for staff guidance specific to oxygen use in the beauty shop.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

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F 329	Continued From page 15	F 329		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to monitor behaviors that warrant the use of antipsychotics for two of four residents (R1, R2) and failed to document the justification to warrant the use of two antipsychotics for one of four residents (R9) reviewed for antipsychotics in a sample of 15.

Findings include:

1. R1's current electronic physician orders document the order for the antipsychotic medication, "Olanzapine 7.5 milligrams at bedtime."

On 12/2/14 at 10:03 a.m., R1 was asleep in a reclining chair in the television lounge of the facility's Rehabilitation Wing.

On 12/1/14 at 9:20 a.m. and 12/02/14 at 3:15 p.m., R1 was ambulating in an enclosed walker in the facility's Rehabilitation Wing. R1 was cooperative and no psychiatric behaviors were noted during these times.

On 12/02/14 at 1:40 p.m., E8, Minimum Data Set/Care Plan Coordinator, confirmed that R1 is being monitored for the following behaviors: Physical Aggression to staff and peers, throwing food, and exit seeking. E8 stated that R1 is physically aggressive mostly toward facility staff, and R1 has had, "a few," episodes of physical

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F 329	Continued From page 16	F 329		

aggression towards other residents.

2. R2's current electronic physician orders document the order for the antipsychotic medication, "Olanzapine 7.5 milligrams at bedtime."

On 12/1/14 at 1:30 p.m., and 12/2/14 at 10:03 a.m. and 3:15 p.m., R2 was sleeping on the couch near the television lounge of the facility's Rehabilitation Wing.

On 12/02/14 at 1:40 p.m., E8, Minimum Data Set/Care Plan Coordinator, confirmed that R2 is being monitored for the following behaviors: increased anxiety, resisting cares, and signs and symptoms of depression. E8 then verified these behaviors do not warrant the use of an antipsychotic medication.

Lexi-Comps Drug Information Handbook for Nursing (8th Edition dated 2007) documents, "Antipsychotic Medication Guidelines...behaviors must be persistent."

On 12/2/14 at 8:30 a.m., E8, Minimum Data Set/Care Plan Coordinator, stated, "We are only able to track the occurrence of behaviors for the last 30 days and it only tracks the number of occurrences per shift." E8 verified the facility could not provide documentation of consistent behaviors exhibited by R1 and R2.

3. R9's current medical record documents R9 is taking Risperidone 1 mg (milligram) at bedtime and was ordered 11/26/13, and Haldol 2 mg at bedtime, last increased 8/26/14. The same record documents R19's diagnosis include Dementia with behavioral disturbances, psychosis and

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F 329	Continued From page 17	F 329		

anxiety.

R9's Note to Attending Physician dated 6/24/14 documents "R9 is currently receiving Risperidone 1 mg at bedtime and Haldol 0.5 mg at bedtime. Black Box Warning: Increase mortality in elderly patients with dementia-related psychosis: Elderly patients with dementia-related psychosis treated with atypical antipsychotic medications are at increased risk of death...treatments with conventional antipsychotic drugs may increase mortality.

R9's quarterly Psychosocial mood behavior notes dated 1/22/14-7/1/14 were reviewed and do not document the justification for the use of 2 antipsychotics.

R9's summary of physician visits dated 11/26/13-10/28/14 were reviewed and did not contain justification for the use of 2 antipsychotics.

On 12/3/14 at 1:00 p.m. E8 (MDS) Minimum Data Set Coordinator stated R9 is on 2 Antipsychotics "because that is what the doctor ordered and the daughter thinks Haldol is effective."

Lexi-Comps Drug Information Handbook for Nursing, 8th Edition dated 2007 documents Coadministration of two or more antipsychotics does not have any pharmacological basis or clinical advantage and increases the potential for side effects.